STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 295023	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 9/1/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON CONVALESCENT CENTER	2898 HIGHWAY 50 EAST CARSON CITY, NV

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 159	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on interviews and observation it was revealed the facility failed to ensure that residents could easily access their spending money seven days a week.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 159	Continued From Page 1

Findings include:

During the confidential group interview conducted on 8/30/05, two alert and oriented residents stated that it was difficult to access small amounts of cash to buy items like soft drinks or treats on the weekend. Staff was not available to access funds on the weekends. The residents stated that they had money stolen and were afraid to keep cash in their rooms, therefore, their spending money was kept by the facility.

Observations of the resident's rooms revealed that there was no mechanism in place to lock money in any of the bedside dressers or closets.

F 159
All residents have the potential to be affected by the deficit practice of inability to access spending money 7 days a week and no mechanism in place to lock money in a bedside dresser/drawer.
The corrective action is that a cash box will be kept at the A-wing nurses station during daytime hours for resident access to their funds: and any resident who wishes to have a locked drawer for locking up money, will have one installed by maintenance.
A survey will be conducted to determine which residents wish to have a locked drawer.
Residents will be notified on admission of this option.
Monitoring will occur via resident council meetings by activity personnel/social services.

10/17/05
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON CONVALESCENT CENTER	2898 HIGHWAY 50 EAST CARSON CITY, NV 89701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of an annual Medicare Re-certification survey which was conducted in your facility from 8/30/05 through 9/01/05. The census at the beginning of the survey was 63 residents. Fifteen residents were in the sample. Two complaints were investigated. The following complaints were investigated: CPT #NV00009282 was a facility reported incident that a resident was injured during a shower. The incident was unsubstantiated for abuse. No citation was written based on the facility's actions. CPT #NV00009024 alleged that the facility failed to ensure that medications were administered to the correct resident. The complaint was substantiated. (See F281) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	F 000		
			CPT # NV 00009024 – see F 281	
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221	F221 Resident # 4 was admitted 8/1/2005. She is non-diabetic and has no restraint. Believe this to be resident # 7, who was admitted 8/5/98 with a DX of Diabetes type I and has a front release seat belt.	

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correct.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elmer L. Seathoff — TITLE: Administrator — (X6) DATE: 9/22/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and interviews, it was determined the facility failed to implement the physical restraint ordered by the physician for 1 of 15 residents (Resident ~~#4~~ 7) and failed to fully assess and attempt to reduce a restraint for 1 of 15 residents (Resident #3). Findings include: Resident ~~#4~~ 1: The resident was admitted to the facility on 8/05/98, with the diagnoses that included, diabetes type I, senile dementia, right-sided hemiparesis, anxiety, dementia with behavior disturbance, peripheral vascular disease and hypertension. On 8/30/05, at 8:35 AM, during the initial tour, the resident was observed in a wheelchair with a back release seat belt. During the day, on two more separate occasions, at 11:50 AM during lunch and also at 2:15 PM in the activities room, the resident was in a wheelchair with a back release seat belt. On 8/30/05, at 3:00 PM, review of Resident #4's medical record revealed a physician order for a front release seat belt when up in wheelchair. The order was signed by the physician on 7/15/05, with an initial order date of 11/14/04. Also, reviewed at that time was a signed informed consent for a front release safety belt when up in wheelchair dated 11/16/04. On 8/31/05, at 10:00 AM, the resident was observed in the activities room in a wheelchair with a back release seat belt. The surveyor interviewed the nurse caring for the resident to	F 221	Resident # 7 Corrected prior to survey exit. All residents have the potential to be affected by the deficit practice of failure to implement the physical restraint ordered by the physician. The corrective action is that C.N.A.s will have daily check off lists for all residents with restraints, to ensure that they have the correct restraint on. Nursing staff will be in-serviced by the SDC or her designee by 9/27/05. (See in-service attachments 2, 9). Monitoring will be done by the SDC, or her designee via review of the check off lists. RECEIVED SEP 2 2 2005 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	9/27/07 and ongoing

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F 221	Continued From page 2 clarify the discrepancy between the current physician orders for a front releasing seat belt and to verify that resident did not have on a dual seat belt that was both, back and front releasing. The nurse and surveyor observed the resident in the activities room at 11:05 AM, on 8/31/05, and the nurse stated that the resident was wearing a back release seat belt, not a dual type of seat belt. The nurse and the DON confirmed the current order for the resident was for a front releasing seat belt and that the resident was in a back release seat belt. The facility failed to ensure that the least restrictive restraint as ordered by the physician was utilized. Resident #3: The resident was admitted to the facility on 6/6/03 with the diagnoses that included senile dementia, depression, anemia, and paranoia. The resident was observed during the survey with a rear releasing seat belt while in her wheelchair. The resident leaned back in the wheelchair and propelled herself around the facility. Review of the record revealed an order and assessment for a rear releasing seat belt on 11/16/03 because the resident leaned forward and had poor safety awareness. Review of monthly follow-up physical restraint reviews for the months of May, June, and July 2005 indicated that the resident was not a candidate for restraint reduction or elimination because she leaned forward and had poor safety awareness. The review on 8/24/05 indicated that a front release seat belt would be requested. Review of nurses' notes in the record beginning on 8/24/05 through 8/31/05 failed to reveal documentation regarding an attempt at restraint reduction. An interview with the DON and nursing staff on	F 221	Resident # 3 Corrected prior to survey exit See F221 – resident # 3 All residents have the potential to be affected by the deficit practice of failure to fully assess and attempt to reduce restraints. The corrective action is that all residents will be reviewed monthly for potential for restraint reduction by the IDT. Requests for potential reduction will be sent to floor nurses for review and implementation as indicated. Monitoring will be done by the IDT each week.	8/31/05 current and ongoing

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F 221	Continued From page 3 8/31/05 revealed the facility's process to reduce restraints. The reviews were done by a team. The recommendation of the team was sent to the staff nurses for comments before implementing a change. For Resident #3 the recommendation was sent to the nurses and that a staff nurse had indicated that a restraint reduction was not recommended. The DON noted that the nurse who made the comment no longer worked at the facility. The staff nurse present at the interview with DON indicated that a trial with a front releasing seat belt and Tabs alarm was appropriate.	F 221		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview it was determined that the facility failed to ensure that the care and treatment provided was done with dignity and in a way that promoted and respected the residents' individuality for 2 of 15 residents (Residents #8 and #6) and the general resident population. Findings include: Resident #8: This 83 year old female resident was first admitted to the facility on 5/04/00, with diagnoses that included general osteoarthrosis,	F 241	F 241 Resident # 8 Care plan corrected – see attachment F241 – resident # 8 See for all residents All residents have the potential to be affected by the deficit practice of failure to promote individual care and dignity to resident's during meal time. All nursing staff will be in-serviced by the SDC, or her designee by 9/29/05 on interacting with residents during meals. (See in-service attachment 2.) Monitoring will occur during routine rounds by licensed and administrative nurses.	9/20/05 9/29/05 and ongoing

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F 241	Continued From page 4 depressive disorder, neurogenic bladder, peripheral vascular disease, senile dementia, anxiety state, hypertension and constipation. A review of the physician orders for Resident #8 revealed a regular pureed diet with nectar thick liquids. A review of the most recent quarterly MDS dated 8/09/05, under the section for physical functioning and structural problems revealed that the resident was totally dependent on staff for all areas of activities with daily living (ADL) including eating. A review of the resident's care plan for problem #2 related to ADL's was dated 5/17/05 and indicated that the, "resident was dependent on staff for ADL completion daily. She requires total care for feeding." A review of the list of six different approaches on the same care plan did not reveal how the staff was to assist or how much assistance was required. The resident was known to be highly cognitively impaired and was observed to always have closed eyes during meal times. There were no approaches listed to communicate with the resident. Observations of the resident each day of the survey during lunch meals taken in the main dining area revealed a resident seated in a wheelchair at the feeding table. The resident was noted to have both eyes closed. The resident was assisted with each bite of the meals by the nursing staff. During meals observed on 8/30/05 and 8/31/05, the staff did not say or communicate to the resident anything related to eating. The facility failed to promote individual care and dignity to Resident #8 during meal times. During the confidential group interview it was	F 241	Group interview All residents have the potential to be affected by the deficit practice of failure to knock on resident rooms prior to entry.	

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F 241	Continued From page 5 revealed that the facility failed to respect the resident's dignity by failing to knock and ask for permission before entering the residents' rooms. Observation of nursing staff each day of the survey revealed that on numerous occasions staff were entering the residents' living areas without knocking. Resident #6: The resident was admitted to the facility on 8/11/04, with the diagnoses that included atrial fibrillation, hypertension, cardiomegaly, osteoporosis, dementia, generalized anxiety, vascular dementia, and decubitus ulcer. Observation of the resident on two occasions, 8/30/05, at 8:15 AM during the initial tour and on 8/31/05, at 11:00 AM in her bed, revealed untrimmed nails with dark brownish black debris under each nail. The nurse caring for the resident was present during the observation. The bath/shower log record was reviewed and it was noted that the resident had not been bathed as scheduled. The facility failed to provide nail hygiene to protect the resident dignity. Cross reference Tag F~~310~~ 312	F 241	All staff will be in-serviced on knocking on resident doors by the SDC, or her designee, by 9/29/05. (See in-service attachment 1, 2, 3). Monitoring will be done during routine rounds by administrative nursing. Resident # 6 Corrected prior to survey exit All residents have the potential to be affected by the deficit practice of failure to provide nail hygiene to protect resident dignity. All nursing will be in-serviced by the SDC or her designee by 9/29/05. (See in-service attachment 2). Monitoring will occur via routine rounds by licensed nursing staff. No F 310 found, believe this to be F 312 Correct.	9/29/05 and ongoing 9/29/05 and ongoing
F 242 SS=C	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242	F 242 Residents # 2 and 13 corrected. Now getting up at 6 am. Resident # 5 Corrected – resident chooses clothing prior to bedtime.	9/20/05

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F 242	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview, it was determined that the facility failed to ensure that residents had a choice about the time they were awakened and got up for breakfast for 2 of 15 residents (Residents #2 and #13) and what was worn the next day for 1 of 15 residents (Resident #5). Findings include: Interviews with Residents #2 and #13 revealed that they were being awakened as early as 5:00 AM for breakfast which was served at 7:30 AM. The residents indicated that they would prefer not to be awakened that early. One resident indicated she tolerated the schedule, but would prefer to sleep later in the morning. Several residents in the group interview indicated that they were awakened too early and preferred to sleep later in the morning. A review of the "Graveyard Get Up List" revealed that each staff member had seven residents to get up between 5:00 AM and 6:30 AM. The assignment list indicated that either 28 or 35 residents would be gotten up depending on the amount of CNA staff. The staff were to also have the resident's clothing, washcloth, and briefs laid out for the day. Resident #5: The resident was admitted to the facility on 5/16/05, with the diagnoses that included diabetes type I, hypertension, depressive disorder, congestive heart failure, dementia with behaviors and psychosis. On 8/30/05, at 1:40 PM Resident #5 was interviewed and during the discussion was asked	F 242	All residents have the potential to be affected by the deficit practice of failure to ensure that residents have a choice about the time that they get up for breakfast and choosing what they will wear. C.N.A.s will be in-serviced on resident preferences by the SDC or her designee by 9/29/05. See in-service attachments 1, 2.) Monitoring will occur via resident council meetings by social services/activity staff.	9/29/05 and ongoing

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F 242	Continued From page 7 "Are you involved in making choices about your daily activities?" The resident stated, "Not about what we wear!" When asked what she meant, the resident said, "They (night staff) come in at 2:00 AM and get our clothes out for the next day."	F 242		
F 246 SS=D	483.15(e)(1), 483.70(c)(1), 483.70(d)(2) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. The facility must provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care. The facility must provide each resident with a separate bed of proper size and height for the convenience of the resident; a clean, comfortable mattress; bedding appropriate to the weather and climate; and functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.	F 246	F 246 Unable to correct for this room as unable to ascertain which resident room this is. Resident # 4 is in room 29, which is a two-bed room. Resident # 6 is in a three-bed room, but no one is lifted with a hoyer in that room. All three-bed rooms were checked to attempt to match all criteria, but there was no direct match. All residents have the potential to be affected by the deficit practice of failure to ensure that the residents' room arrangement and space meets their individual needs. All rooms will continue to be evaluated for resident preference/need as indicated. Monitoring will occur via resident council meetings by social services/activity staff.	9/20/05 and ongoing

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F 246	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure that the residents' room arrangement and space met the individual needs for 2 of 15 residents sampled and one non sample resident (Residents #4, #6 and one non sample resident) and failed to provide accessible chairs for visitors for 3 of 15 residents (Residents #2, #12, and #13). Findings include: On 8/30/05, at 8:10 AM during the initial tour it was noted that three residents, #4, #6 and a non sample resident, lived in one of the rooms. All three of the residents used wheelchairs. Two of the residents were able to propel themselves in their wheelchairs. The room contained three beds, three nightstands, two oxygen concentrators, a large dresser, and a Hoyer lift. On 8/31/05 the non-sample resident was observed sitting in her wheelchair, facing her nightstand and with her back to the door. When the resident was asked if she wanted to attend the activities, she said she had to wait because she could not turn the wheelchair around to propel herself out of the room. The resident's movement was hindered on all three sides. One side by her bed, the other by the night stand and the third due to a privacy curtain pulled around another resident's bed. Two CNAs were behind the curtain using a Hoyer lift to place another resident into her wheelchair so she could be wheeled to the activity room. Due to the arrangement of the furniture and other equipment in the room, the non sample resident's movement	F 246		

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F 246	Continued From page 9 was limited which limited her ability to maintain her independence. While interviewing Residents #2, #12, and #13 in their rooms it was observed that there were no chairs for visitors or the residents to sit in. A visitor in one room was sitting in the resident's wheelchair. One resident stated to sit on the bed as everyone else did. At the exit interview it was revealed that the facility had folding chairs available in a storage closet for visitors. There was no information posted that chairs were available nor did the residents indicate there were chairs available.	F 246	Chairs for resident rooms Corrected. Residents/family members will be notified during the admission process. (See attachment F 246 Frequently asked questions) and during resident council.	9/20/05 and ongoing
F 248 SS=B	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, it was determined that the facility failed to ensure activities in the evenings for 1 of 15 sampled residents and 1 non sample resident. (Resident #5 and 1 non sample resident) Findings include: Resident #5: On 8/30/05 at 1:50 PM, during an	F 248	F248 All residents have the potential to be affected by the deficit practice of failure to ensure evening activities. The corrective action is that residents will be offered 2 evening programs per week after dinner on Monday and Wednesday with an activity employee/volunteer. Activity director/designee will monitor and discuss with residents both during activities and resident council for any changes needed.	9/19/05 and ongoing

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F 248	Continued From page 10 interview of the resident the question was asked, "How do you enjoy the activities at the facility?" The resident responded that they were "good," but that nothing was available after dinner. The resident said, "Sometimes I would like something to do, like play games or hear music or programs." Non-sample Resident: On 8/31/05, at 1:30 PM a resident requested a meeting in her room to discuss several issues. One of the issues discussed was the lack of evening activities. The resident did not want to watch television every night and wondered if something was available after dinner. The resident asked about programs with speakers about history or animals in the evening. On 8/30/05 at 2:50 PM a follow-up interview was conducted with the Activity Director. She said no activities were scheduled after the last one at 2:10 PM because most of the residents went to bed early. Review of the monthly calendar revealed no planned activities in the evenings. On 9/1/05 the Administrator was interviewed and asked about evening activities. He said evening activities were tried a while back, but not attended well. The hours of the Activity Director were 7:30 AM to 4: 30 PM and the activity assistant hours were 8:00 AM to 5:00 PM.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253	**F 253** All the wall covering, (wallpaper, wainscoting) cove base, chair-rail, and broken tiles will be removed from the Nevada room and replaced with new vinyl sheeting, cove base, vinyl chair-rail, and broken tiles by the maintenance department by 10/17/05.	

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F 253	Continued From page 11 Based on observation it was determined, the facility failed to maintain the general maintenance and housekeeping of the lower wheelchair rails in the halls, the wallpaper in the Nevada dining room, the Garden Dining room, and the shower room across from the kitchen. Findings include: On 8/30/05, at 10:50 AM in the Nevada Dining Room it was observed that the coving was pulling away from the walls, especially on the wall by the sink. The lower wallpaper had torn spots, splatters and white spots, along with several seams peeling apart. The wainscoting around the back wall close to the kitchen was nicked and chipped. The kitchen door handle was loose. There was a build up of black residue and broken tile on the floor entering the kitchen. Three of the light bulbs were out in the first chandelier on the right as you entered the room. On 8/30/05 at 10:30 AM, several lower wheelchair railing end pieces were observed to be either missing or broken. The missing or broken end pieces were located in the hallway by: 1) Room #10 to the right of the door frame, 2) the shower room on Long Hall A to the left of the door frame, and 3) the Restorative Aid's office to the left of the door frame, and 4) Room #2 to the left of the door frame. On 9/1/05 at 9:00 AM, the column closest to the nursing station in the Garden Dining room was observed to have a clear plastic protective cover on the corner. The plastic was broken off approximately 36 inches from the floor, level with the dining table. The broken edge was jagged.	F 253	Monthly surveillance checks will be made by the maintenance personnel to ensure continual compliancy. The loose kitchen doorknob has been repaired, and the three burned out light bulbs in the chandelier have been replaced by the maintenance department. Monthly surveillance checks will be made by the maintenance personnel to ensure continual compliancy. The four missing or broken end pieces of the wheelchair railings have been replaced by the maintenance department. Monthly surveillance checks will be made by the maintenance personnel to ensure continual compliancy. The broken clear plastic corner protector on the column closest to the nurse's station in the Garden room has been replaced by the maintenance department. Monthly surveillance checks will be made by the maintenance personnel to ensure continual compliancy. The peeling backboard over the shower tile in the shower room across from the kitchen will be repaired by the maintenance department by 10/17/05. The lint and	08/31/05 08/31/05 09/16/05

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F 253	Continued From page 12 On 8/30/05 at 11:45 AM, the back board over the shower tile was peeling and a portion of the green board was showing in the shower room across from the kitchen. Lint and dust has accumulated on the ceiling vent and on the sprinkler head in the shower room and broken tile was noted on the corner on floor to the left when entering the room.	F 253	dust on the ceiling vent will be cleaned off by the housekeeping staff by 10/17/05. The broken tile will be replaced, and the sprinkler head will be cleaned by the maintenance department by 10/17/05. Monthly surveillance checks will be made by the maintenance personnel to ensure continual compliancy.	10/17/05
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272	F 272 Resident # 4 Respiratory status Corrected prior to survey exit (See attachment F 272 resident # 4 telephone order) All residents have the potential to be affected by the deficit practice of failure to monitor and assess respiratory status. All nursing staff will be in-serviced by the SDC or her designee by 9/29/05 on monitoring/assessing/documenting respiratory status. (See attachments F 272 in-service 1, 2, 10). Monitoring of O2 sat documentation will be done by the licensed nurses. Monitoring of the assessment and documentation will be accomplished via IDT meetings.	8/31/05 9/29/05 and ongoing

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F 272	Continued From page 13 the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to monitor and assess the respiratory status and failed to assess and refer to the social worker psychosocial issues for 1 of 15 residents (Resident #4) and failed to comprehensively assess the skin condition of 1 of 15 residents at risk for pressure areas (Resident #8). Findings include: Resident #4: The resident was admitted to the facility on 8/12/05 following an acute facility stay for a fractured hip and surgery. During the acute facility stay the resident had an exacerbation of chronic obstructive pulmonary disease (COPD). The resident's admission orders included oxygen at 5 liters per minute per nasal cannula and Vicodin every four hours as needed for pain. The order for the oxygen included that it was "okay to titrate." Review of the treatment record revealed that the resident's oxygen saturation level was to be maintained at 90% or greater. Resident #4 was first observed in the dining room at 12:30 PM on 8/30/05. Her oxygen flow rate was set at 3.5 liters per minute. Subsequent	F 272		

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F 272	Continued From page 14	F 272		

observations on 8/30/05 at 1:40 PM and 3:15 PM and on 8/31/05 at 7:30 AM, 8:30 AM, and at 9:50 AM revealed the oxygen flow rate set at 3.5 liters per minute.

The Lippencott Manual of Nursing Practice Sixth Edition, Chapter 9, Page 238 contained a Nursing Alert: "Normally, carbon dioxide levels in the blood provide a stimulus for respiration. However, in patients with COPD, chronically elevated carbon dioxide impairs this mechanism and low oxygen levels act as stimulus for respiration. Giving a high concentration of supplemental oxygen may remove the hypoxic drive, leading to increased hypoventilation, respiratory decompensation, and the development of a worsening respiratory acidosis."

Review of the record revealed that the oxygen flow rate for Resident #4 ranged from 5 liters per minute to 2 liters per minute with a saturation level ranging from 92% to 94% as follows:

Date	Rate	Saturation
8/12/05	5	92%
8/13/05	2	94%
8/14/05 to 8/16/05 no flow rate noted		
8/17/05	2	92%
8/18/05	2	93%
8/19/05	2	92%
8/20/05 and 8/21/05 no flow rate noted		
8/22/05	?	92%
8/23/05	?	92%
8/24/05 and 8/25/05 no flow rate noted		
8/26/05	3	94%
8/27/05	2	92%
8/28/05	3	94%
8/29/05 and 8/30/05 no flow rate noted		

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F 272	Continued From page 15 8/31/05 3.5 94% Review of the notes failed to reveal any assessment activity to support changing the oxygen flow rates in regard to the oxygen saturation levels and/or lung sounds. The observations of the oxygen flow rate at 3.5 liters per minute in light of a diagnosis of COPD was discussed with the nursing staff on 8/30/05. The nurse noted that the resident's saturation level was 96%. In an interview with Resident #4 conducted on the afternoon of 8/31/05, she stated that before her fractured hip and hospitalization her oxygen flow rate was set at 2.5 liters per minute. She asked what the rate was and was told that it was at 3.5 liters per minute. On 8/31/05 the record was reviewed and the concerns about the resident's diagnosis and oxygen flow rate were discussed with the DON. On 8/31/05 Resident #4 was observed in the dining room and asked for an interview after breakfast. The interview with the resident was attempted at 8:30 AM. The resident was tearful and wanted the interview postponed. She stated that she did not like it at the facility. At 8:45 AM an interview was conducted with the Occupational Therapist (OT). The OT stated that the resident was usually happy and that her pain seemed controlled. During the conversation the Physical Therapist stated that the resident did not feel well and did not get her pain pill. Her therapy was postponed. An interview with the resident was completed on the afternoon of 8/31/05. Her mood was improved. The resident explained that, prior to her injury and surgery, she had lived at a group home. She stated that the group	F 272	Resident # 4 psychosocial issues Psychosocial issue corrected. Resident had psych eval and effexor increased. (see attachment F272 phone order and psych eval) 9/12/05 Pain due to hip pinning (see attachment F 272 ortho consult) 9/13/05	

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F 272	Continued From page 16 home was much better than the current facility: the staff were nicer, the food was better, and that she did not have to share a room. The resident was concerned about paying for two places, the group home and the current facility. Review of the record revealed a nursing note dated 8/26/05 that documented that during the night Resident #4 verbalized three times that she was afraid and felt that she was going to die. The resident complained of moderate and severe pain and was medicated at 9:00 PM and at 1:00 AM with Vicodin with only minimal relief. The record failed to reveal evidence of a referral by the nursing staff to the social worker for psychosocial issues. Review of the social workers notes revealed that an initial assessment was done on 8/16/05. The next note was dated 8/30/05 and indicated that the social worker saw the resident with the purpose to investigate a skin tear. The social worker identified that the resident was upset and proceeded to intervene at that time. Resident #8: The resident was admitted to the facility on 5/4/00 with the diagnoses that included osteoarthrosis, depressive disorder, peripheral vascular disease, senile dementia, osteoporosis, and hypertension. Observation of wound care to the resident's pressure area on her right bunion was conducted on 8/31/05 at 2:05 PM. The wound care was completed by the nurse and the nurse was asked if the resident had any other wounds. The nurse stated that she had an area on her buttocks, but that the night night shift changed the dressing every five days. The resident's buttocks was observed and two areas were covered with Duoderm. The resident was noted to have contractures of all four extremities and to be rigid when moved. The nurse was not	F 272	All residents have the potential to be affected by the deficit practice of failure to be referred to social worker for psychosocial issues. licensed nursing will be in-serviced to refer psychosocial issues to the social worker by the SDC or her designee by 9/27/05 (see in-service attachment 1). Monitoring will be accomplished via IDT meetings. Resident # 8 See for all residents All residents have the potential to be affected by the deficit practice of failure to conduct a full body exam to determine if pressure ulcers are present. The corrective action is that nursing will be in-serviced by the SDC or her designee by 9/27/05 on skin check policy and procedure (see in-service attachment 5). C.N.A.s will do daily skin checks and licensed nursing will do weekly skin checks per THI	9/27/05 and ongoing

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F 272	Continued From page 17 observed to conduct a full body examination of the resident to determine if any other pressure areas were present. Review of the resident's care plan revealed that the facility had identified that Resident #8 was at risk for impaired skin integrity related to bowel incontinence, decreased ability to reposition self, skin desensitization to pain/pressure, diagnosis of peripheral vascular disease, daily use of a trunk restraint, contractures, and fragile skin.	F 272	policy and procedure. Monitoring will occur during monthly review of resident record by IDT, Monthly by DON or her designee, and daily monitoring of the C.N.A. skin check sheets by assigned personnel.	9/27/05 and ongoing
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for 3 of 15 residents in the sample and 2 non-sample residents the facility failed to: 1. Monitor and follow-up on the condition of a gastrostomy tube site (Resident #11), 2. Administer medications via a gastrostomy tube in accordance with the physicians orders (Resident #11), 3. Administer a respiratory inhalant in accordance with the facility's policy and procedure and the manufacturer's recommendations (Non-sample resident), 4. Promptly notify the physician that a medication was unavailable and/or consulting with the physician to change the order (Non-sample resident),	F 281	F281 Resident # 11 Corrected prior to survey exit (see attachment F281 resident 11 telephone order). # 1 and 2 All residents have the potential to be affected by the deficit practice of failure to monitor and follow-up on the condition of a gastrostomy tube site and failure to administer medications via a g-tube site in accordance with the physician's orders. Licensed nursing staff will be in-serviced on monitoring and follow-up and administering medication through the g-tube per THI policy	9/1/05

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F 281	Continued From page 18 4. Ensure that medications were administered to the correct resident (Resident #2). Findings include: Resident #11: An observation of the administration of medications via a gastrostomy tube (G-tube) was conducted on 8/31/05 at 9:00 AM. Prior to administering the medications, the nurse commented on the condition of the resident's skin surrounding the tube insertion site. A silver dollar size area was red around the site. The nurse indicated that the design of the tube may have allowed gastric juices to leak and cause skin irritation and redness. She stated that an ointment was applied by the nursing staff. When asked if the physician had been consulted, the nurse stated that he had not because the physician that took care of the tube was different than the resident's primary physician and that the resident would have to be "sent out." The observation and discussion was discussed with the DON on 9/1/05 at 8:45 AM. The nurse then proceeded to administer the Resident #11's medications: Liquid Carafate, liquid multivitamin with minerals, and Metoprolol crushed and mixed with water. The nurse indicated that the resident's tube feeding had been shut off earlier. After checking the placement of the tube the nurse poured approximately 10 cc's of water into a large syringe and added the liquid Carafate without first flushing the G-tube with water. The medication did not flow in with gravity and the nurse pushed it in with the plunger of the syringe. Another 10 cc's of water and the Metoprolol was poured into the syringe followed by water and the multivitamin in the same manner. The tube was then flushed	F 281	and procedure by SDC or her designee by 9/27/05 (see in-service attachment # 6). Monitoring will be done during medication pass with pharmacy consultant. # 3 Non-sample resident – respiratory inhalant All residents have the potential to be affected by the deficit practice failure to administer a respiratory inhaler in accordance with facility policy and procedure and manufacturer's recommendation. All licensed nursing staff will be in-serviced by the SDC or her designee by 9/27/05 on how to administer a respiratory inhaler in accordance with facility policy and procedure and manufacturer's recommendation (See in-service attachment 7). Monitoring will be accomplished via routine rounds by administrative nursing and medication passes with pharmacy consultant.	9/27/05 and ongoing 9/27/05 and ongoing

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F 281	Continued From page 19 with approximately 15 cc's of water. Review of the record revealed a physician order to "Flush G-tube with at least 30 cc's water before and after medication administration and enough water between each medication to clear tube." Review of the facility's Nursing Standard of Practice instructed the nursing staff to flush the tube with 30 cc's of water prior to and after the administration of medications and to clear the tube with five to ten cc's of water between medications. The observation revealed that the nurse failed to flush the tube with water prior to administering the medications and failed to flush the tube between medications in accordance with the physician's order and the facility's Nursing Standards of Practice. Non-sample resident: An observation of a respiratory inhalant, Flovent, was observed on 8/31/05 at approximately 7:00 AM. The resident was in the dining room waiting for breakfast. Two puffs of the medication were administered five seconds apart. Review of the 2005 Geriatric Nurse Handbook found at the nurses' station revealed the recommendation to wait one to three minutes between puffs of Flovent and to rinse the mouth and throat after use. Review of the facility's Nursing Standards of Practice instructed the staff to wait one minute between puffs of respirator inhalants. Non-sample resident: On 8/19/05 the resident's physician wrote an order to discontinue Colace for constipation and to change to Senokot Granules to be given twice a day for constipation. An observation of the medication pass on 8/31/05 at 9:30 AM revealed that the facility had not received the medication from the pharmacy. The nurse explained that, if needed, the resident	F 281	#4 non-sampled resident corrected prior to survey exit see attachment F 281 #4 All residents have the potential to be affected by the deficit practice of failure to promptly notify the physician that a medication was unavailable and/or consulting with the physician to change order. All licensed nursing staff will be in-serviced by the SDC or her designee by 9/27/05 on notifying the physician when medication is unavailable (see in-service attachment 1). Monitoring will occur via administrative nursing notification form that licensed nursing is to fill out if unable to obtain or change medication prior to end of shift. (see in-service attachment 12). Resident # 2 Complaint 00009024 See for all residents. All residents have the potential to be affected by the deficit practice of failure to ensure that medications are administered to the correct resident.	9/1/05 9/27/05 and ongoing

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F 281	Continued From page 20 received medication from facility's bowel protocol for constipation. Review of the medication administration record revealed that the resident was given Milk of Magnesia (MOM) for constipation on 8/29/05. Review of the resident's "Individual BM and Laxative Record" revealed that the resident was given a laxative on 8/23/05 and 8/29/05. Review of the resident's care plan revealed that she had a potential for constipation related to pain medication. Review of the nurse's note on 8/19/05 revealed that the order was sent to the pharmacy. On 8/20/05, 8/21/05, and 8/22/05 the nursing notes indicated that the medication would start when received from the pharmacy. On 8/26/05 a nurse's note indicated that the pharmacy was not able to get Senakot Granules. No follow-up documentation was found. As of 8/31/05 the facility had not received the medication or followed-up with the physician to change the order if appropriate. Resident #2: The resident was admitted to the facility on 6/8/05 with diagnoses including depression, anxiety, diabetes, osteoporosis, gait abnormality, cardiovascular disease, and backache. The resident received medications and on 7/26/05 it was discovered that the resident had taken medications intended for another resident, as the medications of the other resident were inadvertently left at the bedside of Resident #2. The resident received Narcan per physician's order. Investigation by the facility revealed that a nurse	F 281	All licensed nursing staff will complete THI "What you need to know medication management module" by 9/27/05 (see in-service attachments 8). Monitoring will occur during routine medication passes done with pharmacy consultant.	9/27/05 and ongoing

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F 281	Continued From page 21 had violated facility policy by pre-pouring medications and taking them into another resident's room for which the medications were not intended.	F 281		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure that 1 of 15 residents received the necessary services to maintain personal nail hygiene. (Resident #6) Findings include: Resident #6: The resident was admitted to the facility on 8/11/04, with the diagnoses that included atrial fibrillation, hypertension, cardiomegaly, osteoporosis, dementia, generalized anxiety, vascular dementia, and decubitus ulcer. Observation of Resident #6 on two occasions, 8/30/05, at 8:15 AM during the initial tour and on 8/31/05, at 11:00 AM in her bed, during a wound treatment, revealed nails untrimmed and rough, with dark brownish black debris under each nail. The nurse caring for the resident was present when observation was noted by the surveyor. The surveyor and nurse discussed the bathing	F 312	F 312 Resident # 6 – see F 241	

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	295023	A. BUILDING _____ B. WING _____	09/01/2005

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F 312	Continued From page 22 and hygiene routine for the resident. The nurse stated that the resident was scheduled for a bath/shower and hygiene two times a week. The bath/shower scheduling log for the resident was requested and was reviewed at the nursing station. The bath/shower book revealed that the resident was scheduled for a bath/shower on 8/31/05, but resident had not had her bath in the morning based on the record. All of the residents scheduled for bath/shower on 8/31/05, had been bathed or showered as evidenced by the check off mark made by the assigned Certified Nursing Assistants (CNAs). The nurse confirmed with the CNAs assigned to bathe Resident #6 that they had not bathed or provided nail hygiene for the resident. The nurse requested the CNAs to bathe, trim and clean her nails. On 8/31/05, at 3:00 PM the two CNAs were observed completing the resident's bath and the nails were trimmed and cleaned. The facility failed to carry out activities of daily living in regard to providing necessary services to maintain grooming of Resident #6's nails.	F 312		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations and water temperature readings it was determined the facility failed to ensure the water temperature did not exceed 110	F 323	**F 323** The hand-washing faucet in the activities room/Nevada room has had a tempering valve installed by the maintenance department and is set for a maximum temperature 0f 110 degrees.	09/09/05

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F 323	Continued From page 23 degrees Fahrenheit in hand sinks, in 3 resident rooms and in the Activity/Dining room. Findings include: On 9/01/05, at 8:50 AM, the hot water temperature in the Activity Room/Nevada Room hand sink was measured and observed with the Director of Housekeeping present. The temperature of the hot water from the faucet was measured at 154.3 degrees Fahrenheit. On 9/01/05, at 9:50 AM, the hot water temperature from the hand sink in the bathroom in room six, "Short A Hall", was measured and observed with a Certified Nurse Aide (CNA) present who confirmed the reading was 116.4 degrees Fahrenheit. On 9/01/05, at 10:40 AM, the hot water temperature from the hand sink in the bathroom between rooms 24 and 26, "Long A Hall", was measured and observed with a CNA present who confirmed the reading was 121.5 degrees Fahrenheit. On 9/01/05, at 11:15 AM, the hot water temperature from the hand sink in room 32, "B Hall", was measured and observed with the federal surveyor who confirmed the reading was 116.8 degrees Fahrenheit. The hand sinks tested exceeded the recommended 110 degrees Fahrenheit maximum to prevent scalding and harm to the residents.	F 323	The hand sinks in the bathrooms for room six, the bathroom between rooms 24 and 26, and the bathroom in room 32 have been adjusted for a maximum temperature of 110 degrees. Weekly surveillance checks will be made at varying times of the day when hot water demands are different by the maintenance personnel to ensure continual compliancy.	08/30/05
F 324 SS=B	483.25(h)(2) ACCIDENTS The facility must ensure that each resident	F 324	F 324 Resident # 8 For correction, see for all residents	

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F 324	Continued From page 24 receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure that 1 of 15 residents was free of unintended injuries. (Resident #8) Findings include: Resident #8: This 83 year old female resident was first admitted to the facility on 5/04/00, with diagnoses that included general osteoarthrosis, depressive disorder, neurogenic bladder, peripheral vascular disease, senile dementia, anxiety state, hypertension and constipation. A review of the nursing progress notes revealed that Resident #8 suffered skin tears on the following dates: 12/27/04: Resident received a skin tear to left pinky finger during transfer from wheel chair to bed. 3/07/05: Noted skin tear on right elbow during room meal. 4/02/05: Noted a skin tear area of right thumb 3.5 centimeters long. 4/09/05: CNAs were transferring resident in Hoyer lift when the strap on the sling scraped her left arm causing a 6 centimeter skin tear on left arm. 5/12/05: Called and notified DPOA of skin tear to left outer ankle. 6/19/05: Resident moved right forearm under arm of wheel chair resulting in a 2 centimeter skin	F 324	All residents have the potential to be affected by the deficit practice of failure to ensure resident is free of unintended injuries. All nursing staff will be in-serviced on preventing skin tears during transfers by SDC or her designee by 9/27/05 see in-service attachments 11). Monitoring will be accomplished via facility incident reports. Resident # 8 care plan Care plan date on left hand column, inadvertently not changed when new care plan was printed. Goals – column shows date of 8/05 and goals analysis column shows date of 8/05. Care plan corrected. See attachment F 324, resident # 8 careplan. RECEIVED SEP 22 2005 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	9/27/05 and ongoing 9/20/05

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F 324	Continued From page 25 tear. 7/04/05: Resident obtained skin tear left shin during transfer from skin to skin contact. 8/03/05: Resident was found with a 1 centimeter by 1 centimeter skin tear on left hand bottom of thumb. An interview with a staff nurse revealed that skin tears occurred frequently with Resident #8 during transfers and when using the Hoyer lift. A review of the care plan for Resident #8 for the problem of pressure ulcers revealed Approach #4: "Hoyer lift to be used for transfers to prevent skin tears, shearing." No other approach was found in order to prevent skin tears. The care plan origination date was 6/06/03 and did not indicate when the approach was last updated The facility failed to prevent numerous incidents of unintended skin tears. The facility also failed to adequately care plan approaches that would help to prevent further skin tears to Resident #8.	F 324		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the proper concentration of sanitizer to clean the food preparation surfaces. Findings include:	F 371	F 371 All dietary staff will be in-serviced on the recommended concentration of the sanitizer solution and on daily testing by the dietary manager by 9/30/05. Monitoring will be completed by the dietary manager or his designee on a weekly basis.	9/30/05 and ongoing

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F 371	Continued From page 26 A tour of the kitchen was conducted on 8/31/05 at approximately 11:30 AM. A bucket of water with cleaning rags was observed on a preparation table. The kitchen worker explained that the solution was used to wipe down the preparation areas after the breakfast meal. The dietary manager tested the solution with a dip stick for the recommended concentration of sanitizer. The color of the dip stick changed minimally indicating the the concentration of the sanitizer was inadequate. The dietary manager agreed that the strength of the sanitizing solution was inadequate.	F 371		
F 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the	F 432	F 432 All residents have the potential to be affected by the deficit practice of failure to prevent access of eye drop medications by unauthorized persons by leaving the medication on the medication cart, unattended. All licensed nursing personnel will be in-serviced by the SDC or her designee by 9/27/05 on not leaving medications unattended on top of the medication cart. Monitoring will be accomplished via routine rounds by administrative nursing and medication passes with pharmacy consultant.	9/27/05 and ongoing

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F 432	Continued From page 27 facility failed to prevent access of eye medications by unauthorized persons. Findings include: An observation of the medication pass was conducted on the morning of 8/31/05. The nurse parked her cart outside of the dining room and prepared medications for administration. A resident received two different eye drops in addition to oral medications. While the nurse was administering the resident's oral medications and one of the eye drops in the dining room, one of the vials of eye drops was left sitting on top of the cart and out of sight of the nurse. The nurse returned to the cart to get the second vial to administer and left the first vial on top of the cart and out of sight.	F 432		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and policy review it was determined that the facility failed to ensure that the nursing staff practiced hand washing in accordance with the facility's infection control standards of practice. Findings include:	F 444	F 444 All residents have the potential to be affected by the deficit practice of failure to practice hand washing in accordance with facility infection control standards of practice during treatments and medication pass. All licensed nurses will be in-serviced on hand washing procedures during medication pass and dressing changes per THI policy by SDC or her designee by 9/27/05 (See in-service attachment # 4). Monitoring will be accomplished via routine rounds by administrative nursing and medication passes with pharmacy consultant and annual competencies.	9/27/05 and ongoing

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F 444	Continued From page 28 Review of the facility's Standards of Practice for Surveillance, Prevention and Control of Infections revealed the following in regard to hand washing and glove use (in part): "Hand hygiene/hand washing is done before and after patient/resident contact." "After contact with a contaminated object or source where there is a concentration of microorganisms, such as, mucous membranes, not-intact skin, body fluids or wounds." "After removal of medical/surgical or utility gloves." "After contact with a patient's/resident's intact skin." "Hands are washed immediately after gloves are removed, before contact with another patient/resident or the environment." "Hands are washed or decontaminated prior to donning gloves." Observation of medication passes on 8/30/05 and 8/31/05 revealed that the nurse failed to consistently wash her hands or use an antiseptic gel between residents when the administration of the medications required touching the residents. Resident #8: The resident was admitted to the facility on 5/4/00 with the diagnoses that included osteoarthrosis, depressive disorder, peripheral vascular disease, senile dementia, osteoporosis, and hypertension. Observation of wound care to the resident's pressure area on her right foot bunion was conducted on 8/31/05 at 2:05 PM. The nurse obtained the wound care supplies from the medication room at the nurses' station and carried the supplies to the residents room in a large plastic bag. After entering the room the nurse donned a pair of gloves and proceeded to	F 444		

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F 444	Continued From page 29 get the supplies out of the plastic bag. The old dressing was removed and the wound was cleansed with a wound cleanser spray. The nurse took off her gloves and applied a dollop of Biafin, gauze moistened with normal saline, dry gauze, and a clear adhesive dressing with ungloved hands. The nurse was asked about any other wounds. She donned another pair of gloves and exposed two wounds covered with Duoderm on the resident's buttocks. The gloves were removed and the nurse took the bag of supplies down the hall and back to the medication room at the nurses' station. The nurse then washed her hands in the medication room.	F 444		

Carson Convalescent Center

Annual Medicare Recertification Survey

8/30/05 – 9/01/05

Confidential Resident Identifier List

The following numerical identifiers have been assigned to the residents for purposes of confidentiality.

1. Brackney, Thomas
2. Powers, Penny
3. Besio, Patsy
4. Baker, Billie
5. Murr, Sadie
6. Patterson, Beatrice
7. Gore, Leea
8. Titus, Eleanor
9. Angle, Lorena
10. Macareola, Victorino
11. Hunnewell, Allienne
12. Reel, Lucille
13. Spensieri, Pearl
14. Campbell, Mary
15. Sorter, Frederick